TABLE A

Variations in Living Arrangements	Medicaid Eligibility Income Standards (Countable Income)
Licensed Boarding Home:	
Eligible person	$290.00
Eligible couple	580.00
Living Alone or Only with Spouse (also applies in unlicensed boarding home)	
Eligible person	182.00
Eligible couple	250.00
Eligible person living only with ineligible essential person (spouse)	250.00
Living with one or two Other Person(s):	
Eligible person (head of household)	157.70
Eligible person (receiving support and maintenance)	125.00
Eligible couple (head of household)	236.60
Eligible couple (receiving support and maintenance)	224.00
Living with three or More Persons:	
Eligible person (head of household)	157.70
Eligible person (receiving support and maintenance)	105.14
Eligible couple (head of household)	236.60
Eligible couple (receiving support and maintenance)	184.00
Long-Term Care Facility - Includes person in skilled nursing facility, intermediate care facility (A or B) and licensed special hospital (Class B and C). (The Medicaid Cap does not apply to acute care general or Class A Special Hospitals.)	473.10* (Medicaid "cap" Standard)
Long-Term Care Facility (Individual Institutionalized/ spouse in the community or vice versa) - This standard applies for the first month of the individual's (or spouse's) institutionalization and only when couple has been living together prior to institutionalization. After one month, the couple will be considered as two separate individuals.	655.10** (Medicaid "cap" plus one person community standard)

*The Medicaid "cap" is applied to gross income (that is, income prior to application of income exclusions listed in Section 31. of this subchapter).

**The Medicaid "cap" for a couple does not apply when either person is currently receiving SSI.

10:94-4.34 Determination of living arrangements

(a) In order to determine the living arrangement of an individual or couple, the county welfare board shall proceed as follows:

1. If the applicant is the owner (in part or in whole) of the home in which he/she resides, or if he/she is individually or jointly responsible for paying the rent on the residence, the applicant shall be considered as living in his/her own household ("head of household" in Table A).

2. If the applicant does not qualify as an independent household according to paragraph 1 above, the county welfare board shall determine the applicant's pro rata share of the cost of operating the household by dividing total household costs by the number of persons living in the household (including minors). If the applicant's contribution to the household is at least equal to his/her pro rata share of household expenses, the applicant shall be considered as living in his/her own household ("head of household" in Table A).

3. If the applicant is living with other people in a private residence and he/she cannot be categorized in accordance with paragraph 1 or 2 above, the applicant will be considered as living in the household of another ("receiving Support and Maintenance" in Table A).

10:94-4.35 Institutional eligibility

(a) If a person enters a Title XIX participating long term care facility, licensed special hospital or acute care general hospital, he/she shall receive benefits (if he/she meets all other eligibility requirements) as of his/her date of application, which is usually the date of admission.

> Note: The Medicaid "cap" does not apply to persons in acute care general hospitals, Class A special hospitals or non-Title XIX participating long term care facilities. Eligibility of such persons for Medicaid Only is determined according to the income standard applicable to his/her living arrangement in the community.

1. When an individual is determined to be eligible under the Medicaid "cap" and is admitted to a Title XIX long term care facility, certain income deductions shall be made before the calculation of excess income for Medicaid reimbursement purposes:

i. An amount of $25.00 per month for the individual's personal incidental expenses;

ii. For one month only following his/her placement in the facility, $182.00 for the individual's spouse in the community, providing they had been living together immediately prior to the placement;

iii. An amount of $118.00 per month for each dependent child under 21 years of age who is not a recipient of AFDC or AFWP.

2. Any temporary absence, during which the individual remains a patient of the institution, does not interrupt a continuous stay in the institution.

10:94-4.36 Eligibility under pay-as-you-go agreements

(a) A person who has legally transferred his/her resources to a facility in return for support and maintenance may still be eligible for Medicaid Only if the value or the support and maintenance combined with any other income does not exceed the appropriate standard for that individual's type of living arrangement.

1. When a facility has a monthly per capita cost figure, such figure is determined by totaling the yearly expenses of the facilities, dividing this figure by the average number of residents per month, and then dividing this figure by 12. This gives the per capita cost per month for each resident. This amount is then counted as unearned income to the individual. (Note: The person would be allowed the $20.00 monthly unearned exclusion deducted from the total of his/her unearned income.)

2. When there is no available reliable evidence from which to determine per capita costs, the value of support and maintenance is determined according to the following:

	Individual	Couple
Shelter	$20.00	$30.00
or		
Shelter plus one or all utilities or	$37.00	55.00
Shelter plus utilities plus some or all furnishings	$43.00	64.00
Meals (three a day)*	$45.00	$90.00

*If both meals and shelter are provided, the applicable amounts are added together.

3. With pay-as-you-go agreements, once the value of the person's resources that were transferred to the facility are fully utilized for support and maintenance, no further deductions will be made for support and maintenance.

10:94-4.37 Eligibility under life care agreements

(a) An individual who has legally transferred his/her resources to a facility in return for support and maintenance for life with a life care agreement may be eligible for Medicaid Only if the value of the support and maintenance combined with any other income does not exceed the appropriate standard for the person's type of living arrangement.

1. The value of support and maintenance is determined as outlined above under pay-as-you-go agreements (section 36 of this subchapter). The deduction of support and maintenance under life care situations continues to be applied throughout the validity of the agreement, even though the cost of support and maintenance at some point exceeds the total value of the person's transferred resources.

10:94-4.38 Responsibility regarding the reporting of income and resources

Responsibility regarding the reporting of income and resources shall be shared by the applicant and the county welfare board.

10:94-4.39 Applicant responsibility

At the time of application or redetermination, the applicant shall report all income currently being received, and all resources held by him/her, as well as by those persons whose income and resources are deemed available to him/her. The applicant shall also identify any income or resources (including deemed income and resources) which he/she expects to receive during the period of eligibility. The applicant shall immediately inform the county welfare board of any change in his/her income or resources.

10:94-4.40 Responsibility of county welfare board

The county welfare board shall determine that the applicant's total income and resources (including deemed income and resources), as reported during the application or redetermination interview, are completely and definitively identified on the application form, and in detail sufficient to permit verification. In addition, the county welfare board shall verify, and document in the case record, all information relating to the applicant's income and resources (if necessary).

SUBCHAPTER 5. DETERMINATION OF CONTINUING ELIGIBILITY

10:94-5.1 Redetermination of eligibility

(a) The eligibility of each case shall be redetermined at regular intervals and at least every 12 months. This redetermination provides an opportunity to evaluate the total situation and enables the income maintenance worker to ascertain whether the individual's eligibility has changed.

(b) It shall be the agency's responsibility to review indications of ineligibility as they occur and to discontinue "Medicaid Only" when appropriate and without delay.

naturalization service conditions have to be met before any person can become a naturalized citizen:

1. A naturalized citizen, unless automatically naturalized as outlined above, should have his/her naturalization certificate as proof of citizenship. If the applicant does not have this document, the county welfare board should contact the nearest immigration and naturalization service district office to verify that the applicant meets the requirements of a naturalized citizen.

(c) The status of an alien shall be verified by means of one of the following:

1. An alien who is legally in the United States should have documentation to that effect since he/she is required by law to carry it. The alien should have in his/her possession a form I-151, Alien Registration Receipt Card, or an older frrm AR-3 and AR-3a, Alien Registration Receipt Card, or a reentry permit. Any of those cards can be accepted as verification that the alien has been lawfully admitted to the United States for permanent residence. If the applicant does not have one of these documents, the county welfare board should contact the nearest immigration and naturalization service district office to verify that the applicant is lawfully admitted to the United States.

2. There are special sections of the Immigration and Nationality Act which allow the Attorney General discretion in allowing conditional entry into the United States. Entry into the United States may be for reasons of national catastrophe, persecution or fear of persecution on account of race, religion, or political opinion, and so forth. Individuals in these categories will have form I-94, Arrival - Departure Record, citing the section of the Immigration and Nationality Act under which admitted. This form will be acceptable evidence of permanent residence.

3. An alien who is lawfully admitted for a specific period of time only will be in possession of one of the following documents: Arrival - Departure Record (I-94) for aliens other than parolees or refugees; Canadian border crossing card (I-185); Mexican border visitors permit (SW-434); crewman's landing permit (I-95A0; crewman's landing permit and identification card (I-184). Such persons are not eligible for participation in the Medicaid Only program.

10:94-3.4 Residence requirement

An applicant for or recipient of Medicaid Only shall be a resident of the State of New Jersey.

10:94-3.5 Resident defined

(a) The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

(b) County residence is not an eligibility requirement and relates only to identification of the welfare board charged by law with responsibility for the official receipt, registration, and processing of applications. The county welfare board is responsible for institutionalized (including nursing homes, intermediate care facilities, and sheltered boarding homes) applicants and recipients within its county regardless of previous county of residence.

10:94-3.6 Change of county residence

(a) Responsibility for case management shall be transferred from one county to the other when a recipient moves to another county.

(b) A temporary visit by the recipient shall not be considered to be a change of county residence until that visit has continued for more than a three month period.

1. Whenever it is determined that a recipient whose application has not been validated has changed or is planning to change his/her residence from one county to another, the CWB of original shall continue medical assistance while completing validation, subject to the time limits set forth in the application process, then transfer the case without delay to the receiving county in accordance with the next paragraph. If the CWB of original is in the process of obtaining medical records, it shall complete the process and forward the medical records to the receiving county.

2. Whenever it is determined that a recipient whose application has been validated displanning to change his/her residence from one county to another, it shall be the responsibility of the county welfare board directors of the two counties concerned to effect the transfer without interruption of medical assistance.

3. The county of origin shall initiate and the receiving county shall, on request, immediately cooperate in accomplishing a full investigation of the circumstances surrounding the move.

4. If the move is permanent and the case warrants continued medical assistance, transfer of the case shall be accomplished expeditiously by discontinuance of medical assistance in the county of origin and award of medical assistance in the receiving county, to occur simultaneously in the first month for which the county welfare board directors mutually so arrange.

5. The welfare of the client shall not be adversely affected and his/her right to uninterrupted medical assistance if in need shall not be prejudiced by disagreement or other administrative difficulty between the counties. Any adverse change in grant resulting from transfer requires timely notice.

Note: Since the Medicaid Only client retains the same Medicaid number when he/she moves from one county to another, the county of origin shall not terminate the client from the Medicaid status file, but only from its own register.

(c) The county welfare board directors shall mutually determine the dates of case transfer, issuance of medical assistance and the extent of case documents to be forwarded. The receiving county welfare board shall forward notice of receipt of medical assistance.

(d) Any case in which transfer procedures are not mutually agreed upon by the county welfare board directors concerned within 30 days of the date of original referral, shall be promptly reported by the county of origin to the State division by letter, setting forth the pertinent available facts. This does not mean that the actual transfer must be completed within 30 days, but rather that an understanding between county welfare board directors shall be concluded within that time.

10:94-3.7 Eligibility of recipients who leave New Jersey

(a) Whenever a recipient wishes to leave New Jersey either to establish a permanent residence or for a temporary visit, he/she shall be advised of the effect of this plan on his/her eligibility for continued assistance. Particular care should be taken to advise the recipient how to present his/her New Jersey Medicaid validation stub and instruct the provider where to send the bill, should the recipient need medical care or hospitalization while out of the State on an approved temporary visit.

(b) It shall be the policy of this State that if a recipient leaves New Jersey with intent to establish a permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, or if he/she decides to remain indefinitely in the place outside New Jersey to which he/she had gone for a temporary visit, he/she ceases to be eligible to receive assistance.

(c) Visits by a recipient for a period of not more than 30 days will be permitted without affecting the recipient's eligibility. Absence for longer periods of time must be approved by the Division of Public Welfare.

10:94-3.8 Medicaid eligibility for individuals who enter New Jersey in order to secure medical care

(a) Federal and State statute and regulations expressly bar a duration-of-residence requirement as a condition of eligibility. The New Jersey

Medical Assistance and Health Services Act authorizes a grant of medical assistance to a qualified applicant who is a resident of the State which "...means a person living, other than temporarily, within the State."

(b) When an individual enters this State in order to receive medical care, and applies for Medicaid to meet all or a portion of the costs of such care, the fact that the immediate purpose of the move was to secure medical care does not, in and of itself, have the effect of making this person ineligible for the medical assistance program. It is the responsibility of the county welfare board to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

1. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;

2. Whether the move is part of a carefully conceived social service plan which would serve to meet other requirements of the individual in addition to purely physical needs, for example, a person moves to a nursing home in order to be closer to relatives who are interested in the persons welfare;

3. Whether there is a clear expression of intent on the part of the individual to remain permanently in this State;

4. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he/she came;

5. Whether the State in which the individual previously resided recognizes him/her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

(c) If, after full consideration of these factors, the county welfare board is satisfied that the individual has become a resident of this State, then eligibility for medical assistance is established if the person is otherwise eligible.

10:94-3.9 Age

(a) Age requirements are:

1. The applicant must be 65 years of age or older to be eligible based on age alone.

2. A disabled or blind child must be under 18 years of age, or under 22 years of age and a student regularly attending school and neither married nor the head of the household.

3. A disabled or blind adult must be over 21 years of age and under 65 years of age or between 18 years of age and 22 years of age if not a full-time student.

(b) The applicant must present acceptable proof of age. Among acceptable sources of verification of age are:

1. Birth certificate;
2. Marriage certificate;
3. Church records - baptismal, confirmation membership;
4. Immigration or naturalization papers;
5. Census records;
6. School records;
7. Military service records;
8. Court records;
9. Employment records;
10. Records of public or private welfare agencies;
11. Voting records;
12. Medical records;
13. Affidavit from disinterested persons;
14. Driver's licenses; or
15. Insurance policies.

(c) County welfare boards shall maintain administrative controls to assure:

1. That a disabled or blind recipient who becomes 65 years of age continues to have his/her eligibility determined on the basis of disability or blindness if it appears more advantageous to the recipient;

2. That a disabled child recipient is processed as a disabled adult when reaching 18 years of age, or 22 years of age and a student regularly attending school and neither married nor the head of the household;

3. That a disabled child recipient is processed as a disabled adult when reaching 18 years of age and a student regularly attending school and either married or the head of a household.

10:94-3.10 Disability and blindness factors

For purposes of determining medical eligibility for the Medicaid Only program, the disability and blindness standards shall be the same as for the Supplemental Security Income program under Title XVI of the Social Security Act, as amended by Public Law 92-603.

10:94-3.11 Determination of disability and blindness eligibility; a State function

(a) The determination of disability and blindness eligibility for the Medicaid Only program is a direct responsibility of the medical review team in the Bureau of Medical Affairs. Determination of all other factors of eligibility is the responsibility of the county welfare boards. The medical review team is composed of a medical consultant and a medical social work consultant; it reviews Medicaid Only applications submitted by the county welfare board.

(b) In situations where an applicant's disability or blindness appears to meet the definition in section 12 of this subchapter, presumptive eligibility for either of these factors can be granted with the approval of the medical review team (MRT) in the Bureau of Medical Affairs.

(c) If an individual has been determined disabled for Social Security purposes (that is, he/she is currently receiving disability insurance benefits), the county welfare board shall not be required to refer the individual to the Bureau of Medical Affairs for a determination of medical eligibility. The individual shall be considered automatically eligible, in this respect, for Medicaid Only benefits.

10:94-3.12 Disability; definitions

(a) An individual is disabled for purposes of this part if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity).

(b) A physical or mental impairment is an impairment which results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. Statements of the applicant including his/her own description of his/her impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment.

(c) An individual is "blind" for purposes of this part if he/she has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having central visual acuity of 20/200 or less.

(d) The presence of a condition diagnosed as addiction to alcohol or drugs will not itself be the basis for a finding that the individual is or is not under a disability.

10:94-3.13 County welfare board responsibility and procedures

(a) It is the responsibility of the CWB to furnish the medical review team with current, pertinent social and medical information, and to obtain any special or additional reports on request.

(b) When it appears that an applicant meets the income and resources requirements for Medicaid Only, arrangements for obtaining medical evidence should be initiated immediately by whichever of the following procedures is applicable to the applicant's situation.

1. When the applicant is currently (within three months) under the care of a private physician, he/she shall be furnished with a copy of form PA-5 (Examining Physician's Report) to take to the physician for completion.

2. If the applicant is currently receiving treatment in a hospital clinic, public health facility (that is, tuberculosis clinic, mental health clinic or other outpatient facility) on a regular basis for the medical condition related to his/her application for Medicaid Only, a copy or abstract of the clinic record may be submitted in lieu of the PA-5.

3. If the applicant has been hospitalized within three months for a condition related to the impairment for which he/she is applying for Medicaid Only, an abstract of the hospital record may be submitted for patients in long term care facilities.

4. In the event none of the above are applicable, the CWB should assist the applicant in choosing a physician to complete the PA-5 who is competent to determine the nature and extent or degree of disability.

5. When the applicant states that he/she is blind or that visual impairment is his/her primary disability, the CWB shall, prior to submission of the record to the medical review team, obtain a report of eye examination (form PA-5A) from a qualified medical specialist in diseases of the eye (for example, ophthalmologist), or from an eye clinic of a general hospital. (The membership directory of the Medical Society of New Jersey is suggested as a reference for identification of, in each municipality, physicians specializing in diseases of the eye.) The PA-5A should be transmitted, in duplicate to the MRT together with any other pertinent medical evidence as outlined above. When appropriate, the certification of need for patient care in facility other than public or private hospital (PA-4) will be submitted to the Bureau of Medical Affairs.

(c) Other evidence, such as education, training, work experience, and daily living activities shall be submitted to the MRT by completion of the PA-6 (Medical-social information report). The PA-6 shall be carefully and completely filled out.

(d) If the applicant refuses to furnish medical or other evidence concerning his/her disability, the application for Medicaid Only shall be referred to the Bureau of Medical Affairs for recommendations.

(e) As soon as medical reports and the medical-social information report (PA-6) are completed, one copy of each shall be stapled together for transmittal to the Bureau of Medical Affairs. It shall be clearly indicated on the PA-6 that this is a Medicaid Only case. Records transmitted by CWB on a given date shall be listed by registration number and name on an inventory sheet, prepared in duplicate, the cases being grouped by case status. One copy shall be attached to the submittal records, the duplicate retained as CWB control.

(f) The Bureau of Medical Affairs will prepare a similar inventory and attach cases returned to the CWB on a given date. Attached to each will be form PA-8, record of action, containing the determination of eligibility by the MRT and any necessary instructions.

(g) Upon receipt of records from the Bureau of Medical Affairs, the CWB shall examine the PA-8 (record of action) for the action of the medical review

team and for specific instructions or recommendations, and to note the review date.

(h) Recommendations will be made by the medical consultant to alert the CWB to the possibilities of adequate medical care for the client, and to provide specific pertinent questions to be raised with the attending physician. The medical social work consultant will make recommendations to help the CWB staff recognize the social problems indicated in the client's situation and the relationship between these problems and his/her physical and mental adjustment.

(i) The following procedures shall be observed in respect to MRT actions:

1. "Approved" cases:

i. CWB shall complete, as necessary, determination of eligibility in respect to other factors and, if applicant is eligible, take the necessary action to obtain Medicaid benefits.

ii. When an applicant is not eligible in respect to any other factor, although "approved" for the disability or blindness factor, the application shall be denied.

iii. The county welfare board shall establish and maintain a control file for "approved" cases in order that the date for redetermination review by the MRT will be observed and considered according to instruction in subchapter 5 of this chapter.

iv. The Bureau of Medical Affairs shall also maintain a control file in order to ensure appropriate and timely reevaluation by the MRT. The Bureau of Medical Affairs will notify county welfare boards one month in advance of cases scheduled for such review. Cases also for reevaluation will be listed on form PA-655.

2. "Undetermined" cases:

i. If further medical and/or social information is required by the MRT for the initial determination of eligibility, the CWB shall obtain the information promptly and resubmit the case. Reports from medical specialists shall be submitted on their own letterheads.

ii. If the applicant fails or refuses to present himself/herself for required examinations or tests, the application shall be referred to the MRT for recommendations.

3. "Disapproved" cases:

i. Any case determined as not medically eligible for "Medicaid Only" by the MRT shall be denied Medicaid Only by the county welfare board.

ii. Appropriate notification shall be given to the applicant as well as any specific recommendations for follow-up care and treatment.

(j) When page 5 of form PA-5 carries the signature of the medical consultant approving the payment of the examining physician, such payment

shall be forwarded to the physician from administrative funds, regardless of whether the action on the record of action is "approved", "disapproved" or "undetermined". (In an "undetermined" case, if the request for additional information relates to an incomplete report from the examining physician, approval for payment will not appear on page 5 of the PA-5.)

(k) Payment for special diagnostic reports shall likewise be forwarded to the medical specialist or clinic from administrative funds regardless of whether the case is "approved", "disapproved", or "undetermined".

(l) Maximum allowances for examining physician (completion of PA-5) are:

1. Examination at office or hospital: $15.00;
2. Examination at patient's home: $20.00;
3. Examination at public institution: No fee.

(m) Diagnostic examination services rules are:

1. This section is concerned with medical specialty consultant evaluation services and diagnostic studies (that is, clinical laboratory, diagnostic x-ray and special diagnostic examinations) incident thereto, authorized by a county welfare board upon recommendation of the MRT, when deemed essential as part of the initial determination of medical eligibility.

2. These examinations and procedures are exclusively for diagnostic eligibility, are chargeable as matchable administrative costs and a medical vendor payment should be promptly made upon approval of the consultant's report by the reviewing physician employed by the State agency.

3. The following schedule of fees is exclusive of laboratory, x-ray and other special diagnostic studies which may be required:

i. Diagnostic consultation and report (ophthalmologic includes refraction; otological includes audiometric screening) other than psychiatric or neurologic $35.00;

ii. Diagnostic consultation requiring complete psychiatric or complete neurological examination or complete neuropsychiatric examination, with detailed report .....$40.00.

(n) Payment of the above allowance is to be approved only when the specialist has received prior authorization to perform the diagnostic evaluation and when the examination is performed by a qualified specialist (that is, eligible for or certified by the appropriate American board; or recognized by hospital, community and peers as a specialist, and practice is limited to the specialty). See current membership directory of the Medical Society of New Jersey.

(o) The fee(s) listed in fees for professional and diagnostic services issued by the Medical - Surgical Plan of New Jersey (Revised 6-1-73) shall be approved when diagnostic x-ray or radioisotope studies, laboratory and/or special diagnostic studies are deemed essential by the medical specialist authorized to perform the diagnostic consultant evaluation. Payment based on the allowances

listed by the Medical - Surgical Plan, Series 575, shall be limited to medical specialists as defined in this section.

10:94-3.14 Institutional eligibility

(a) Persons who are otherwise eligible for Medicaid Only receive medical coverage while receiving patient care in eligible medical institutions. Such coverage shall be provided through the appropriate payment mechanism of the Division of Medical Assistance and Health Services. The Medicaid "CAP" income standard is applied only to certain institutions. Persons in public institutions are not eligible for Medicaid coverage.

(b) An "institution" is any group living arrangement in which food, shelter and personal care (other than nursing care) are furnished on a continuous basis to four or more persons unrelated to the operator or in which food, shelter and personal care, including nursing care, are furnished on a continuous basis to four or more persons unrelated to the operator; or any establishment or facility licensed or approved by the State of New Jersey.

(c) Application of Medicaid "CAP" rules are:

1. General or Class A special hospitals: When a person is confined to such a hospital, the Medicaid "CAP" standard does not apply.

2. Long term care facilities (eligible private medical institutions): This may include licensed nursing homes (skilled nursing facilities), intermediate care facilities, or Class B and C special hospitals. These facilities must be licensed by the Department of Health licensing authority, and approved by the Department of Institutions and Agencies for provider participation in the Title XIX Medicaid program. When person is confined to a long term care facility, the Medicaid "CAP" standard is used.

3. Licensed boarding homes for sheltered care (including nonprofit incorporated homes for the aged): These homes must be approved by the Department of Health. When the person is in a facility of this type, the income standard for licensed boarding home is used.

(d) An "eligible medical institution" outside New Jersey is a public or voluntary medical institution which is licensed, certified or approved by the proper authority of the jurisdiction in which the institution is located, so that the costs of care and services provided therein may be paid. Evidence of such license, certification or approval shall be obtained from the Department of Welfare or similar authority of the jurisdiction in which the institution is located.

1. Use of out-of-State facilities shall be restricted to temporary emergency situations where it is established that there is no eligibility for coverage under a welfare or nonwelfare program in the other state.

10:94-3.15 County welfare board responsibility and procedures; eligibility factors

(a) The CWB shall be responsible for determining income and resource eligibility, as outlined in subchapter 4 of this chapter, for Medicaid Only when applicant is receiving care in institutions defined above. This does not include residents of the State psychiatric hospitals, the State schools for the mentally retarded, Bergen Pines County Psychiatric Hospital, and Essex County Hospital Center, which are the responsibility of the institutional services section of the Division of Public Welfare.

(b) When eligibility depends upon the disability or blindness factor, the determination of medical eligibility shall be the responsibility of the medical review team. The CWB shall furnish the MRT with current, pertinent social and medical information as outlined in this subchapter.

(c) When eligibility for Medicaid Only has been determined, the county welfare board will complete and process a Medicaid Status File Transaction, form MAP-1, within ten working days from the date of such determination. The county welfare board will issue and distribute medicaid validation stubs to Medicaid Only recipients who are not in long term care facilities. The CWB will complete the statement of income available for nursing home payment (PA-3L) when appropriate.

(d) A determination of continuing eligibility shall be made in accordance with subchapter 5 of this chapter.

10:94-3.16 Medical assistance units

(a) The Division of Medical Assistance and Health Services has local offices throughout the State, known as local medical assistance units (LMAU). The role of these offices is to provide liaison with providers of health services, provide information about Medicaid to recipients and to members of the community, provide utilization review in determining the medical need for certain covered services requiring prior authorization, and provide information about Medicaid to and cooperate with appropriate agencies in order to insure maximum utilization of the services available through the Medicaid program.

(b) Any questions with respect to policy, regulations, or procedures of the Medicaid program should be directed to the appropriate LMAU listed below:

Local Medicaid Offices

Atlantic	1601 Atlantic Avenue, 6th floor Atlantic City (609) 344-2861
Bergen	50 Main Street, 1st floor Hackensack (201) 488-5667

Burlington	Chesley and Alloway Bldg., 2nd floor Route 38 and Eayrestown Road Mount Holly (609) 261-0448
Camden	530 Cooper Street, 2nd floor Camden (609) 365-3926
Cape May	1601 Atlantic Avenue, 6th floor Atlantic City (609) 344-2861
Cumberland	7 East Broad Street Bridgeton (609) 451-6550
Essex	155 Washington Street Newark (201) 648-2470 505 South 15th Street Newark (201) 648-3700
Gloucester	42 Delaware Avenue Woodbury (609) 845-7185
Hudson	100 Newkirk Street, 5th floor Jersey City (201) 792-6390
Hunterdon	6 Court Street Flemington (201) 782-1130
Mercer	316 East State Street Trenton (609) 292-7315
Middlesex	75 Paterson Street, basement New Brunswick (201) 246-0653
Monmouth	320 Broad Street Red Bank (201) 842-6440
Morris	4 Court Street Morristown (201) 267-1700
Ocean	1851 Hooper Avenue Toms River (201) 255-6226
Passaic	152 Market Street Paterson (201) 523-2800
Salem	42 Delaware Avenue Woodbury (609) 845-7185
Somerset	6 Court Street Flemington (201) 782-1130
Sussex	4 Court Street Morristown (201) 267-1700
Union	7 Bridge Street, 4th floor Elizabeth (201) 355-8860
Warren	6 Court Street Flemington (201) 782-1130

SUBCHAPTER 4. RESOURCES AND INCOME

10:94-4.1 Financial eligibility standards; resources

As a condition of eligibility for the Medicaid Only program, applicants must comply with the resource standards set forth in this subchapter.

10:94-4.2 Resources defined

For the purposes of this program, a resource shall be defined as any real or personal property (that is, asset) which is owned by the applicant (or by those persons whose resources are deemed available to him/her, as described in this subchapter) and which would be converted to cash to be used for his/her support and maintenance. Both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of this subchapter.

10:94-4.3 Availability of resources

(a) In order to be considered in the determination of eligibility, a resource must be "available". A resource shall be considered available to an individual when:

1. The individual has the right, authority or power to liquidate real or personal property, or his/her share of it; or
2. Resources have been deemed available to the applicant.

10:94-4.4 Evaluation of resources

(a) The value of a resource shall be defined as the price that the resource would command if offered for sale on the open market in the individual's locality (that is, its current market value). Debts owed on a resource shall be ignored when determining current market value.

(b) In cases of joint or multiple ownership, only the individual's (or couple's) pro rata share of the property shall be considered a resource.

(c) The evaluation of resources by the county welfare board shall be based upon statements made by the applicant regarding the resource's estimated value, unless such statements are unclear, inconsistent, or incomplete.

1. The county welfare board shall evaluate the applicant's past circumstance and present living standards in order to determine the possible existence of resources which may not have been reported. If the applicant's resource statements appear questionable, or the county welfare board has reason to believe that total identification of resources is incomplete, the county welfare board shall verify the applicant's resource statements with one or more third parties.

2. If third party contact is required under the provisions of this subsection, the applicant shall cooperate fully with the verification process. If necessary, the applicant shall provide written authorization allowing the county welfare board to secure the appropriate information.

10:94-4.5 Countable resources

Any asset which is not specifically excludable under the provisions of this subchapter shall be considered a countable resource for the purposes of determining Medicaid Only eligibility.

10:94-4.6 Liquid resources

(a) An accessible resource which can be liquidated or negotiated within 20 working days, such as, but not limited to, cash, demand deposits, time deposits, United States bonds, securities, and notes receivable, shall be countable as a liquid resource.

1. If verification is required in accordance with the provisions of N.J.A.C. 10:94-4.4(c), the county welfare board shall definitively establish the existence or nonexistence of liquid resources with appropriate institutions, such as, banks, credit unions, brokerage firms, savings and loan associations, and so forth.

2. Appropriate institutions, as cited in this section, shall be defined as those institutions which are in close proximity to the applicant's residence, and/or which have, at any time, provided services to the applicant.

10:94-4.7 Nonliquid resources

(a) An accessible resource which cannot be liquidated or negotiated within 20 working days, such as, but not limited to, buildings, land, boats, and aircraft, shall be countable as a nonliquid resource.

1. If verification is required in accordance with the provisions of this subchapter, county welfare board shall proceed in the following manner:

i. Informational inquiries regarding motor vehicle ownership will be addressed, in writing, to the Bureau of Office Services, Division of Motor Vehicles, 25 South Montgomery Street, Trenton, New Jersey 08625. Such inquiries should identify, by name and address, each person about whom information is being requested. The names of encumbrance holders will be supplied by the Division of Motor Vehicles only when specifically requested by the county welfare board.

ii. If the county welfare board determines that it is necessary to establish whether or not real property is producing income consistent with its

fair market value, inquiry shall be made of local real estate brokers, tax assessors, or other persons knowledgeable of the prevailing rate of return on real property in the community.

iii. If the county welfare board determines that a vehicle is not totally excludable as a resource, inquiry shall be made of one or more local used or new car dealers in order to determine the current market value of the resource.

iv. If the county welfare board determines that certain household goods and/or personal effects are not excludable as a resource, inquiry shall be made of one or more local merchants who deal in used household or personal goods in order to determine the current market value of the resource.

10:94-4.8 Documentation of verification

Any verification which occurs in connection with the determination or evaluation of resources shall be fully documented in the case record.

10:94-4.9 Liquidation of resources

In the cae of a nonliquid resource which causes the applicant's total countable assets to exceed the standards found in section 440, the county welfare board will assist the applicant in the development of a plan for liquidation. Medicaid Only benefits may be granted by the county welfare board prior to the liquidation of such resources.

10:94-4.10 Liquidation period

(a) The applicant shall have six months in which to dispose of real property, and three months in which to dispose of other property. If he/she can show good cause for failure to liquidate, the county welfare board may extend the liquidation period for an additional three months. The liquidation period shall begin as of the date of application or, in the case of disabled applicants, on the date that disability is determined.

1. Real property shall be offered for sale at an asking price named by the applicant but not less than the price set by an independent appraisal paid for by the CWB. Any purchase offer at a lower price must be approved by the CWB.

2. Good cause shall be defined as the inability to find a buyer after the asset has been placed on the open market for the period of time prescribed in this section and a reasonable effort to sell has been made.

10:94-4.11 Redetermination following liquidation

Immediately upon liquidation of any nonliquid resource, the applicant's eligibility shall be redetermined based on the net proceeds of such sale. (Net proceeds are the moneys remaining after encumbrances and costs of the sale have been deducted.)

10:94-4.12 Excess resources after liquidation

If, after liquidation, the applicant's resources exceed the appropriate resource maximum, benefits shall be terminated until such time as the applicant's resources fall within the applicable limits.

10:94-4.13 Inability to liquidate

If a resource cannot be liquidated within the period cited in section 10 of this subchapter, the county welfare board shall consider the asset inaccessible, and therefore excludable under section 16 of this subchapter. Inaccessible assets of this type shall be reevaluated (regarding their accessibility) at every redetermination.

10:94-4.14 Refusal to cooperate

If, at any time, the applicant refuses to cooperate with the development of a plan of liquidation, or with the liquidation proceedings, benefits shall be terminated immediately, in accordance with appropriate regulations.

10:94-4.15 Excludable resources

A resource which is classified as excludable shall not be considered either in the deeming of resources or in the determination of eligibility for participation in the Medicaid Only program.

10:94-4.16 Identification of excludable resources

(a) The following resources, and only the following resources, shall be classified as excludable:

1. A house occupied by the individual as his/her place of principal residence, and the land appertaining thereto, to the extent that the combined value of such does not exceed $25,000.

i. The amount by which the value of such a resource exceeds $25,000 shall be countable toward the appropriate resource maximum.

ii. The value of the home shall be the tax assessed value of the property multiplied by the reciprocal of the assessment ratio as recorded in the most recently issued State table of equalized valuations.

(1) Example: The City of Trenton considers a home to be worth $20,000 for tax purposes. The State table of equalized valuations shows an assessment ratio of 66 2/3 per cent for the City of Trenton. The value of the house, for Medicaid Only purposes, would be $30,000.

2. One vehicle used for household transportation, to the extent that the value does not exceed $1,200:

i. The amount by which the value of a vehicle used for household transportation exceeds $1,200 shall be countable toward the appropriate

10:94-5.2 Requirements

The individual, or his/her authorized representative, shall execute a formal written application for continuance of assistance at least once every 12 months.

10:94-5.3 Process of redetermination

(a) The IM worker shall conduct a face to face interview regarding application for continuance of Medicaid Only and shall assist in the completion of the continuation form, if necessary.

(b) The IM worker shall review all eligibility factors in accordance with the provisions set forth in subchapters 3 and 4 of this chapter. Particular attention shall be directed to identification of any changes in resources and income.

(c) It is the responsibility of the IM worker to complete a new Medicaid eligibility worksheet (PA-1E) and form PA-3A when eligibility is to be continued, or suspension of eligibility continues beyond one month, or the case is terminated.

(d) Official review of this factor on a routine basis is not required, but when medical or social evidence indicates that specific determination should be made, the CWB shall institute such an investigation.

10:94-5.4 Recording and recommendation

(a) A summary report of all pertinent information shall be made for each contact with the individual, whenever it occurs. Whenever a change in circumstances affects any facet of eligibility, a Medicaid eligibility worksheet, form PA-1E and a form PA-3A shall be prepared. The summary shall clearly state the basis for any suspension of eligibility or termination.

(b) Following each redetermination of eligibility, it is the responsibility of the IM worker to recommend on the PA-3A form that eligibility be continued, suspended, or terminated.

10:94-5.5 Disposition of application for continuation

(a) Following supervisory approval, an application for continuation shall be acted upon by one of the following methods:

1. The director of welfare (or his/her authorized representative) shall, by his/her legal authority, continue, suspend or terminate eligibility when, in his/her judgment, such action should be taken in advance of welfare board action. Such cases shall thereafter be presented to the welfare board at its next meeting.

2. The following applications for continuation shall be routinely presented to the welfare board for decision:

i. Cases recommended for continuance;

ii. Cases recommended for suspension or termination (for ratification if acted upon by director);

3. Whenever a special review results in a recommendation of suspension or termination, the case shall be presented to the welfare board for initial action or ratification of the director's action, as appropriate.

10:94-5.6 Notice of agency decision

Each applicant shall receive written notice of any agency decision which relates to his/her eligibility status at least ten days prior to any change in his/her eligibility status.

10:94-5.7 Redetermination of disability and blindness factor

(a) There shall be redetermination of the factors of disability and blindness for every Medicaid Only recipient at intervals set by the Bureau of Medical Affairs, except those who are currently receiving SSA disability insurance benefits. The redetermination review date is designated on form PA-8, record of action.

(b) An individual who has been determined to be disabled or statutorily blind shall, if requested with reasonable notice, present himself/herself for and submit to examinations or tests, and shall submit medical and other evidence necessary for the purpose of determining whether he/she continues to be disabled or statutorily blind.

(c) Procedures for County Welfare Board are:

1. Scheduling of "redetermination review" date:

i. In Medicaid Only cases, CWB shall take into account the redetermination review date on the record of action in scheduling both the annual review and interim visits. CWB may adjust the date for case submittal to the Bureau of Medical Affairs to coincide as closely as is practical with either the annual review or with an interim visit, but such adjustment shall assure that the case will be submitted not more than two months earlier or later than the date originally set on the record of action.

ii. In addition, the Bureau of Medical Affairs shall maintain a control file in order to ensure appropriate and timely reevaluation by the MRT. The Bureau of Medical Affairs will notify county welfare boards one month in advance of cases scheduled for such review by means of form PA-655.

2. The IM worker shall so organize his/her caseload controls (notebooks, index, and so forth) that he/she will be alerted sufficiently in advance of redetermination review dates to enable him/her to obtain any specific medical information or reports requested on the last record of action. The data and reports so submitted must be "current".

3. When a case is to be submitted to the Bureau of Medical Affairs for redetermination review, the IM worker shall prepare form PA-6A, Interim Medical-Social Report in detail. Form PA-6A shall be placed on top of all forms, reports and related data previously submitted.

4. Medicaid coverage shall be continued, if financial and resource eligibility continues to exist, unless and until CWB is advised by the Bureau of Medical Affairs that the individual no longer meets the disability and blindness requirements or withdraws voluntarily.

5. Upon receipt of records from the Bureau of Medical Affairs, the CWB shall follow the procedures as outlined in subchapter 3 of this chapter.

SUBCHAPTER 6. CASE RECORDS AND FILES

10:94-6.1 Purpose of case records

The case record is a complete record in support of the county welfare board's decisions and actions for each case.

10:94-6.2 Contents of the case record

(a) The following items shall be included in the case record:

1. The narrative recording; and

2. All medical reports and record of action from the MRT (appropriate cases); and

,3. All forms related to financial eligibility; and

4. All related correspondence, memoranda and documents except those which are required by law and regulation to be maintained in some other files.

10:94-6.3 Forms applicable to the Medicaid Only program

Forms applicable to the Medicaid Only program (aged, blind and disabled) are listed on page 1 of Appendix A; sample forms follow that list.

10:94-6.4 Maintenance and custody of case records

All case record material relevant to each family shall be maintained under an appropriate registration number. All records shall be appropriately indexed and filed.

10:94-6.5 Movement of case records

(a) No case record or offical part of such record shall be removed from its designated filing cabinet without an identifying record of the person who has custody of it.

(b) No case record or official part shall be removed from the offices of the

county welfare board except at the specific authorization of the director, deputy director or duly designated representative of the director.

10:94-6.6 Retention and destruction of records

For policy and procedure on retention and destruction of case records see Public Assistance Manual 7270.

SUBCHAPTER 7. OTHER PAYMENTS

10:94-7.1 General provisions

Medicaid Only recipients, like supplemental security income recipients, are eligible to receive services and related service payments for services identified in section 2 of this subchapter and for payment of burial and funeral expenses as authorized in section 5 of this subchapter. Such payments as deemed necessary and appropriate by the county welfare board shall be paid either directly to the vendor of the service or by a check issued to the eligibile person.

10:94-7.2 Services and service payments

Eligible applicants and recipients as defined under the State Plan for Title XX of the Social Security Act may receive the services and related service payments specified in the State Plan. The Division of Youth and Family Services is responsible for providing the county welfare board with policies and procedures regarding these service programs, including these specified in section 3 of this subchapter.

10:94-7.3 Other service payments

Eligible applicants and recipients of Medicaid Only are also eligible to receive service payments authorized in Section 510 of the Assistance Standards Handbook. This includes payments for expenses incident to homemaker service, travel costs for health care, and child care in certain situations.

10:94-7.4 Emergency assistance payments

Eligible applicants and recipients of Medicaid Only are not eligible to receive emergency assistance as defined in Section 530 of the Assistance Standards Handbook.

10:94-7.5 Payment of burial and funeral expenses

The county welfare board is directed, under certain situations, to provide payments for burial and funeral expenses on behalf of Supplemental Security Income (SSI) and adult "Medicaid Only" recipients, as well as formal Old Age Assistance, Disability Assistance and Assistance for the Blind recipients. The

procedure authorizing these payments is in chapter 300, Payment of Burial and Funeral Expenses, in the Handbook - Special Payments for the Aged, Blind, and Disabled. (Until that document is available, refer to authorization contained in Circular Letter No. 73-12-1, issued by the Division of Public Welfare on 12/4/73).

SUBCHAPTER 8 OTHER RESPONSIBILITIES

10:94-8.1 Notice of county welfare board decision

The county welfare board shall notify the applicant for or recipient of Medicaid Only promptly of any agency decision in writing. The policies and procedures outlined in the Public Assistance Manual, Section 7100, Notice of county welfare board decision, shall be followed.

10:94-8.2 Complaints and fair hearings

(a) It is the right of every applicant for or recipient of Medicaid Only to be afforded the opportunity for a fair hearing before the State agency in the manner established by the policies and procedures set forth in the Public Assistance Manual, chapter 6000, Complaints and Fair Hearings.

(b) In situations where an applicant or recipient is denied medical services to which he/she feels he/she is entitled, a request for a hearing and a brief explanation of the situation should be sent to:

Director
Division of Medical Assistance and
Health Services
324 East State Street
Trenton, New Jersey 08625

10:94-8.3 Fraudulent receipt of assistance

To protect the assistance agency and the public against the commission of fraud, the policies and procedures as defined in the Public Assistance Manual, Section 7800, Fraudulent Receipt of Assistance, shall apply to the Medicaid Only program.

10:94-8.4 Reporting criminal offenses to law enforcement authorities

Investigation of new applications or investigations for redetermination of eligibility may on occasion present indications to the county welfare board that a crime may have been committed. In such a situation, the procedures outlined in the Public Assistance Manual, Section 7900, Reporting Criminal Offenses to Law Enforcement Authorities, are to be followed.

10:94-8.5 Safeguarding information

The Federal Social Security Act requires that a state must provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of public assistance. Therefore, the policies and procedures outlined in the Public Assistance Manual, Section 7600, Safeguarding Information, apply to the Medicaid Only program.

10:94-8.6 Nondiscrimination in public assistance programs

Title VI of the Federal Civil Rights Act of 1964 (Public Law 88-352) prohibits discrimination on the grounds of race, color or national origin in the administration of a program for which Federal funds are received. Therefore, the policies and procedures relating to this act, as outlined in the Public Assistance Manual, Section 7700, Nondiscrimination in Public Assistance Programs, are to be strictly observed.

APPENDIX A

FORMS APPLICABLE TO THE MEDICAID ONLY PROGRAM

PA-1C	Inquiry for Medical Assistance
PA-1E	Medicaid Eligibility Worksheet
PA-1G	Application and Affidavit for Medical Assistance Only (Aged, Blind, or Disabled), Cuban Refugee Assistance and Medical Assistance for the Aged
PA-1H	Application for Continuation of Public Assistance (MA, MAA, and CRA)
PA-2D	Summary Report
PA-3A	Worksheet and Authorization for Public Assistance
PA-3L	Statement of Income Available for Nursing Home Payment
PA-4	Certification of Need for Patient Care in Facility Other than Public or Private Hospital
PA-5	Examining Physician's Report
PA-5A	Report of Eye Examination
PA-6	Medical-Social Information Report
PA-6A	Interim Medical-Social Report
PA-7	Report of Findings by Psychiatric Diagnostic Group
PA-8	Record of Action - Medical Review Team
PA-655	Notification of Cases Due for Reevaluation by Medical Review Team